

1124

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u> 05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Harmond Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Winfield</u> Middle <u>S.</u> Last <u>Beall</u>		4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Beall</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Perry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Calcified aortic stenosis</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> </u> 19 <u> </u> to <u> </u> 19 <u> </u> , that I last saw the deceased alive on <u> </u> and that death occurred at <u>12:15</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>2195 Washington St. Easton 16, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		DATE SIGNED <u>26 Nov 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Vienna</u>		22d. LOCATION (City, town, or county) (State) <u>Vienna Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rich S. McIntyre</u>		ADDRESS <u>Easton Market</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Krause</u>	
DATE <u>JAN 28 '59</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Place of Birth

Age at Death

Sex

Color

Signature

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01127

CERTIFICATE OF DEATH

1150

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>TALBOT</u>		STATE <u>MARYLAND</u>		COUNTY <u>CAROLINE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL ST MICHAELS</u>		LENGTH OF STAY (in this place) <u>2 MOS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>DENTON</u>		<u>05X-2</u> ✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARY</u> <u>BOWMAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN</u> <u>26</u> , 19 <u>59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov</u> <u>1955</u>	9. AGE last birthday <u>93</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Smith</u>				14. MOTHER'S MAIDEN NAME <u>Annie Woodall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs Wm. S. Orme, Denton, Md.</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Artery Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>53</u> , to <u>Jan 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan 25</u> , 19 <u>59</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above. SIGNATURE <u>John H. Harrison</u> M.D. <u>EASTON Maryland</u> DATE SIGNED <u>26 Jan 59</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 28, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Odd Fellows'</u>		LOCATION (City, town, or county) (State) <u>Camden, Del.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	
DATE <u>JAN 29 '59</u>							

CERTIFICATE OF DEATH

1130

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

INTERMITTENT CAUSE

ACUTE CAUSE

CHRONIC CAUSE

TERMINAL CAUSE

PRE-MORAL CAUSE

POST-MORAL CAUSE

OTHER CAUSE

PLACE OF DEATH

DATE OF DEATH

AGE

SEX

OCCUPATION

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

INTERMITTENT CAUSE

ACUTE CAUSE

CHRONIC CAUSE

TERMINAL CAUSE

PRE-MORAL CAUSE

POST-MORAL CAUSE

OTHER CAUSE

PLACE OF DEATH

DATE OF DEATH

REMARKS

REMARKS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01128

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe Rd</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe Rd</u> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Delena</u> First <u>ANN</u> Middle <u>BROOKS</u> Last		4. DATE OF DEATH Month <u>Jan</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 18, 1958</u>	9. AGE (In years last birthday) yrs. <u>78</u>	IF UNDER 1 YEAR Months <u>78</u> Days <u>18</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Eugene Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Doris Copper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Doris Brooks</u> Address <u>Trappe Rd Md.</u>	
18. CAUSE OF DEATH [Enter only one cause or line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>763.0</u> DUE TO <u>U.R.I. - 1 wk</u> Conditions, if any, which gave rise to immediate cause (b) <u>U.R.I. - 1 wk</u> (c) <u>U.R.I. - 1 wk</u> DUE TO <u>U.R.I. - 1 wk</u> cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>10 AM</u> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Lewis M. Welty</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-5-59</u>	
EXAMINER'S NAME (Type) <u>WELTY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Williamson Co</u>	22d. LOCATION (City, town, or county) <u>Easton</u>	(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Doherty</u>		ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 8 59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Usual residence: _____

7. Cause of death: _____

8. Manner of death: _____

9. Signature of medical examiner: _____

10. Date: _____

CERTIFICATE OF DEATH

01129

Reg. Dist. No.

1152

1. PLACE OF DEATH a. COUNTY Talbot		b. STATE Maryland		c. COUNTY Talbot	
5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X St. Michaels	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rio Vista Nursing Home		d. STREET ADDRESS St. Michaels		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Conner		4. DATE OF DEATH Month Day Year January 8 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1878	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? u s a		13. FATHER'S NAME Thomas Conner		14. MOTHER'S MAIDEN NAME Martha Jewell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Earl Conner 1806 No. Gay Balto 13 Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) subarachnoid hemorrhage 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atherosclerotic cerebrovascular DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Immediate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, Essential vascular		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 11-17 , 19 54 to 1-8 , 19 59 , that I last saw the deceased alive on 1-8 , 19 59 , and that death occurred at 1:30 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) St. Michaels Md DATE SIGNED 1-9-59					
ACTUAL SIGNATURE Guy M. Regner		PHYSICIAN'S NAME (Type) Guy M. Regner			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 10, 1959		22c. NAME OF CEMETERY OR CREMATORY Springhill	
22d. LOCATION (City, town, or county) (State) Easton, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall - St. Michael, Md		ADDRESS St. Michael, Md		24a. RECD BY REGISTRAR JAN 13 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thayer					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of Deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of Birth</p>	
<p>5. Place of Birth</p>		<p>6. Usual Residence</p>		<p>7. Date of Death</p>		<p>8. Time of Death</p>	
<p>9. Cause of Death</p>		<p>10. Manner of Death</p>		<p>11. Signature of Physician</p>		<p>12. Signature of Registrar</p>	
<p>13. Signature of Informant</p>		<p>14. Address of Informant</p>		<p>15. Date of Report</p>		<p>16. File Number</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01130

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Cook</u> Last <u>Cook</u>				4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Bl</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 23, 1959</u>	
9. AGE (In years last birthday) yrs. <u>11</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>30</u>		IF UNDER 24 HRS. Hours <u>11</u> Min. <u>30</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Jerome Gilbert Cook</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Viola Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Barbara Cook</u> Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Prematurity</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>Jan</u> Day <u>23</u> Year <u>1959</u> Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>Jan. 23, 1959</u> , to <u>Jan. 23, 1959</u> , that I last saw the deceased alive on <u>Jan. 23, 1959</u> , and that death occurred at <u>5:30 p. m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald J. Butler</u> M.D.				ADDRESS (Street, city or town, state) <u>9 M. HANSEN ST. EASTON, MD</u>			
DATE SIGNED <u>1-23-59</u>							
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Incineration</u>		22b. DATE THEREOF <u>1/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Hospital</u>		22d. LOCATION (City, town or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>—</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 29 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

2080203XVO

CERTIFICATE OF DEATH

1901

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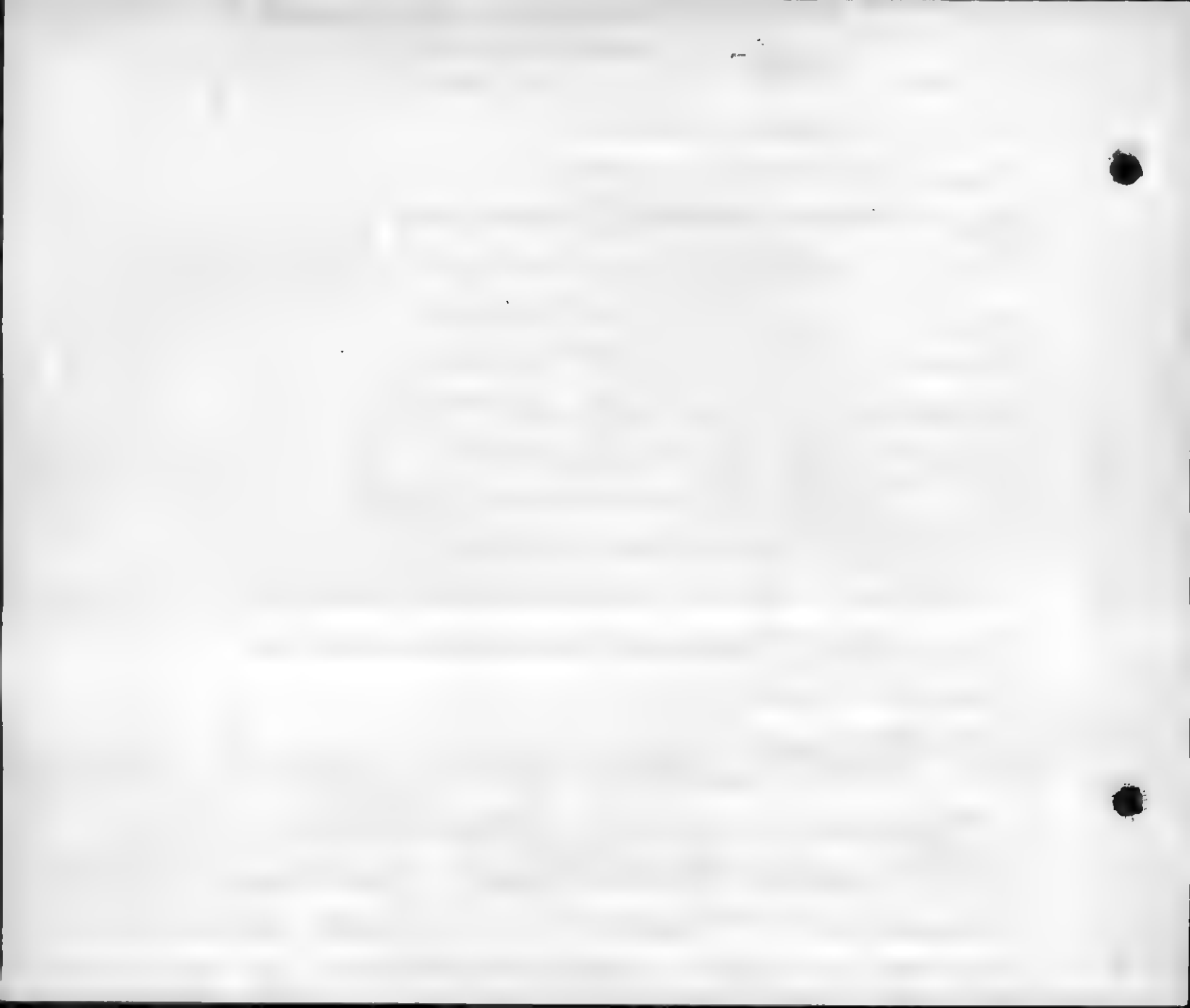
1901

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 14 Filed 2-8 1-23-59 at
1126
CERTIFICATE OF DEATH

01131

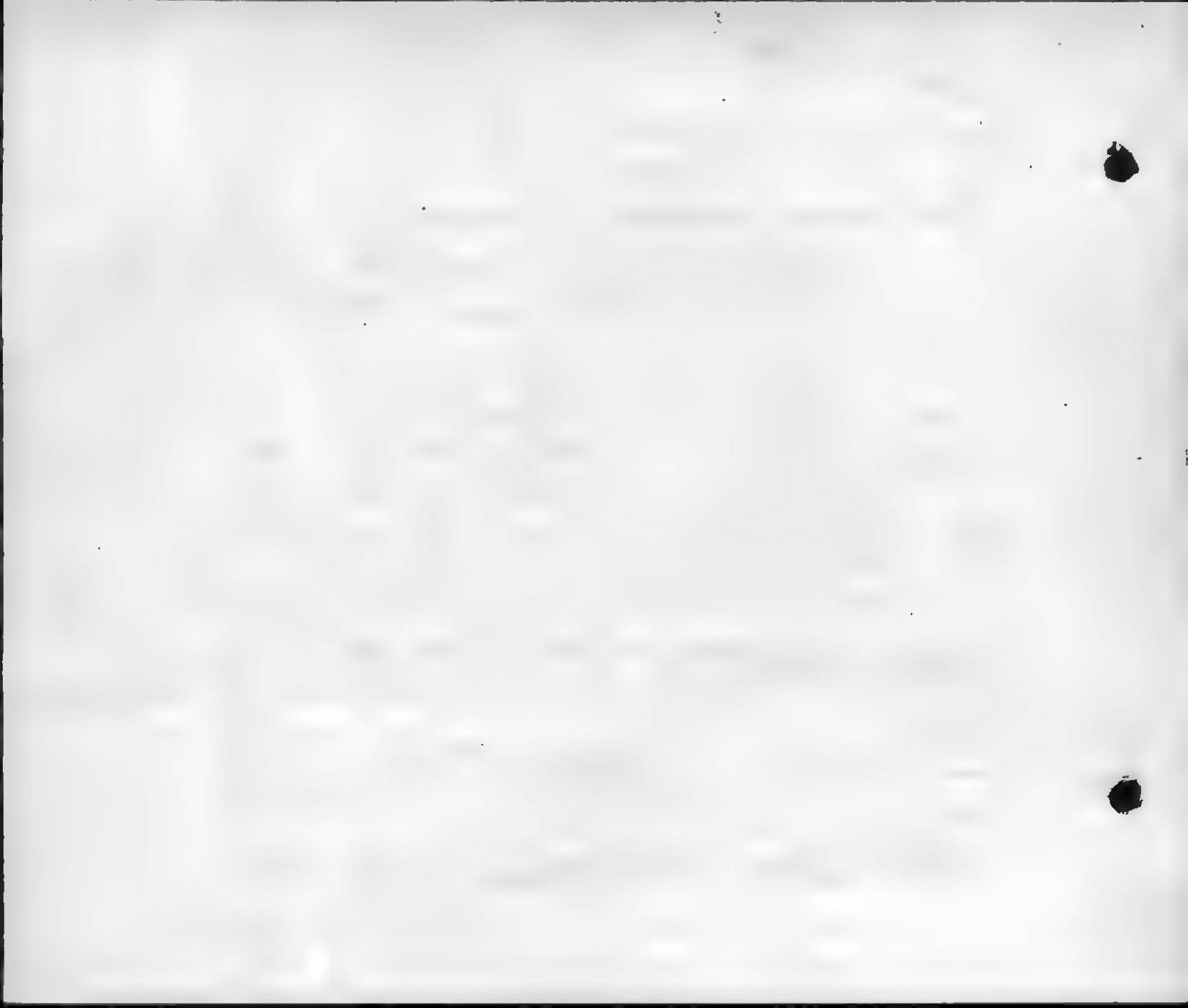
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESTON			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELY RURAL		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSP.			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First AGNES Middle CROUSE Last CROUSE			4. DATE OF DEATH Month JAN Day 13 Year 1959		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 29, 1890	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house		10b. KIND OF BUSINESS OR INDUSTRY house		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME EMMANUEL KING			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Donald Crouse Ridgely Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Choccal compression 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart was huge into neck DUE TO (c) Rupture of aneurysm					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.					
ACTUAL SIGNATURE E. C. H. Schmidt		M.D. 2195 Washington St		DATE SIGNED 15 Jan 59	
NAME (Type) E. C. H. Schmidt		ADDRESS (Street, city or town, state) Easton 16, Maryland		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 17, 1959		22c. NAME OF CEMETERY OR CREMATORY Denton	
22d. LOCATION (City, town, or county) Denton, Md		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. Virgil McCreedon		ADDRESS Denton		24a. REC'D BY REGISTRAR AN	
24b. REGISTRAR'S SIGNATURE William S. Kline		DATE 15 59			



MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/55



1128

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queens Town</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>E</u> Last <u>Dutcher</u>		4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Dutcher</u>		14. MOTHER'S MAIDEN NAME <u>Flora Russell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis - left hemiplegia</u>			
332X DUE TO (b) <u>cerebral atherosclerosis</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral atherosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 Dec</u> 19 <u>58</u> to <u>7 Jan</u> 19 <u>59</u> that I last saw the deceased alive on <u>7 Jan</u> 19 <u>59</u> , and that death occurred at <u>3:35 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton, Maryland</u> DATE SIGNED <u>7 Jan 59</u>	
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN MAUSOLEUM</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGES'S CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co</u> ADDRESS <u>2901-14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

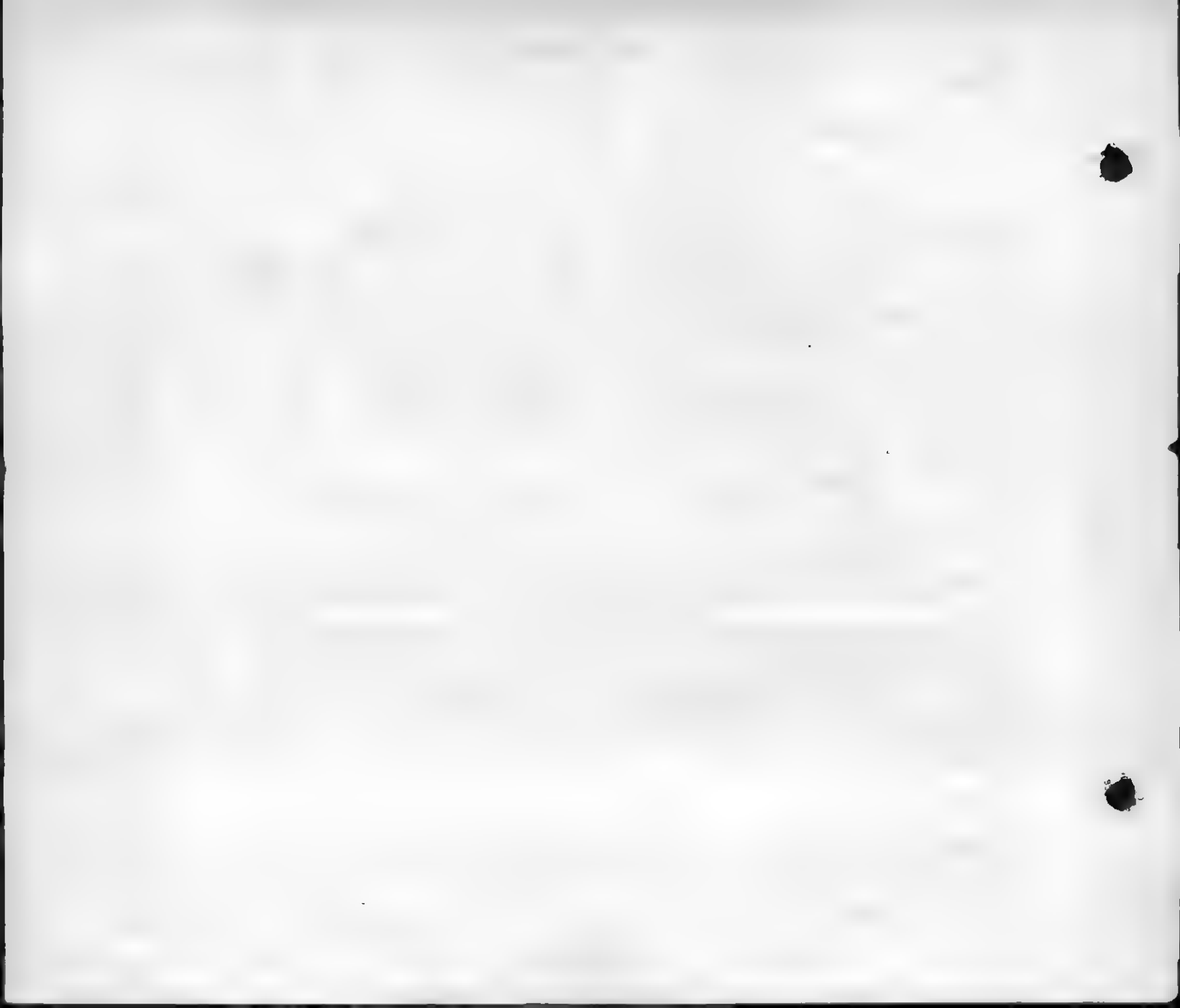
03548

1129

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>42 hr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>A.</u> Last <u>Dyott</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 20, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Duval</u>		14. MOTHER'S MAIDEN NAME <u>Ella Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>UNK.</u>	
17. INFORMANT <u>JAMES T. DYOTT, EASTON, R.D.MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Encephalomalacia, recent & old -</u>			
X DUE TO <u>Myocardial Infarct</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 29, 1959</u> to <u>Jan. 29, 1959</u> , that I last saw the deceased alive on <u>Jan. 29, 1959</u> , and that death occurred at <u>12:22 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		DATE SIGNED <u>31 Jan 59</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>219 S. Washington ST Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN MEM.</u>	22d. LOCATION (City, town, or county) (State) <u>EASTON, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Thompson</u>		ADDRESS <u>Easton, MD.</u>	
24a. REC'D BY REGISTRAR <u>APR 1 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



1130

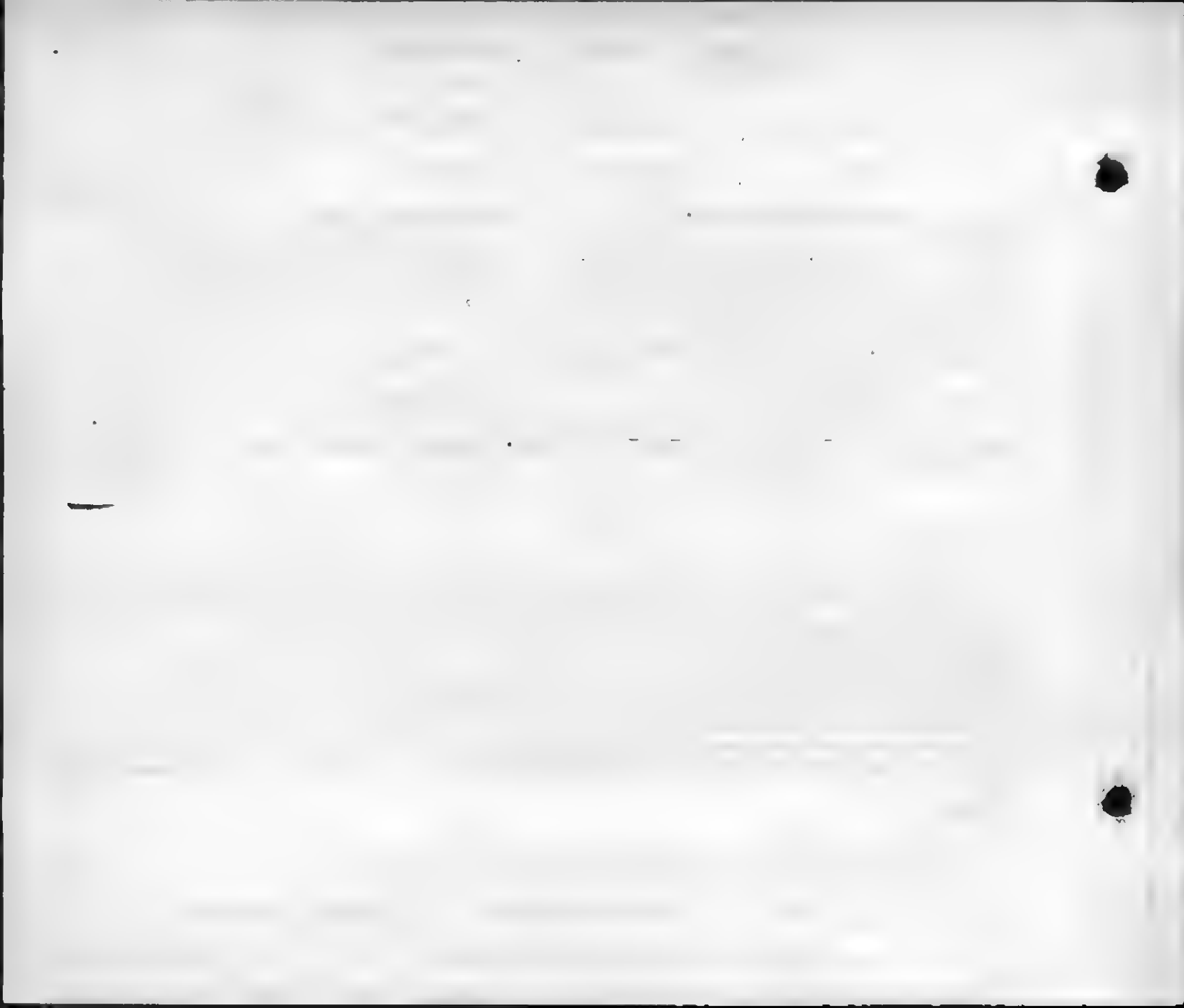
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton			
c. LENGTH OF STAY IN 1b 5 yrs				d. STREET ADDRESS 412 Goldsboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 412 Goldsboro St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Katie Middle Colgan Last Gibson				4. DATE OF DEATH Month January Day 22 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1881	
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown --				16. SOCIAL SECURITY NO. 220-01-6388			
17. INFORMANT Mrs. Jane Dobson, Easton, Maryland				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 22, 1959 to Jan 22, 1959 , that I last saw the deceased alive on Jan 22, 1959 , and that death occurred at 5 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald F. Bartley M.D.				ADDRESS (Street, city or town, state) 9 N. HANSON ST. DATE SIGNED 1-23-59			
PHYSICIAN'S NAME (Type) DONALD F. BARTLEY M.D.				EASTON, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/59		22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		22d. LOCATION (City, town, or county) (State) Oxford Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Thompson Easton, Maryland				24a. REC'D BY REGISTRAR JAN 27 '59		24b. REGISTRAR'S SIGNATURE W. H. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

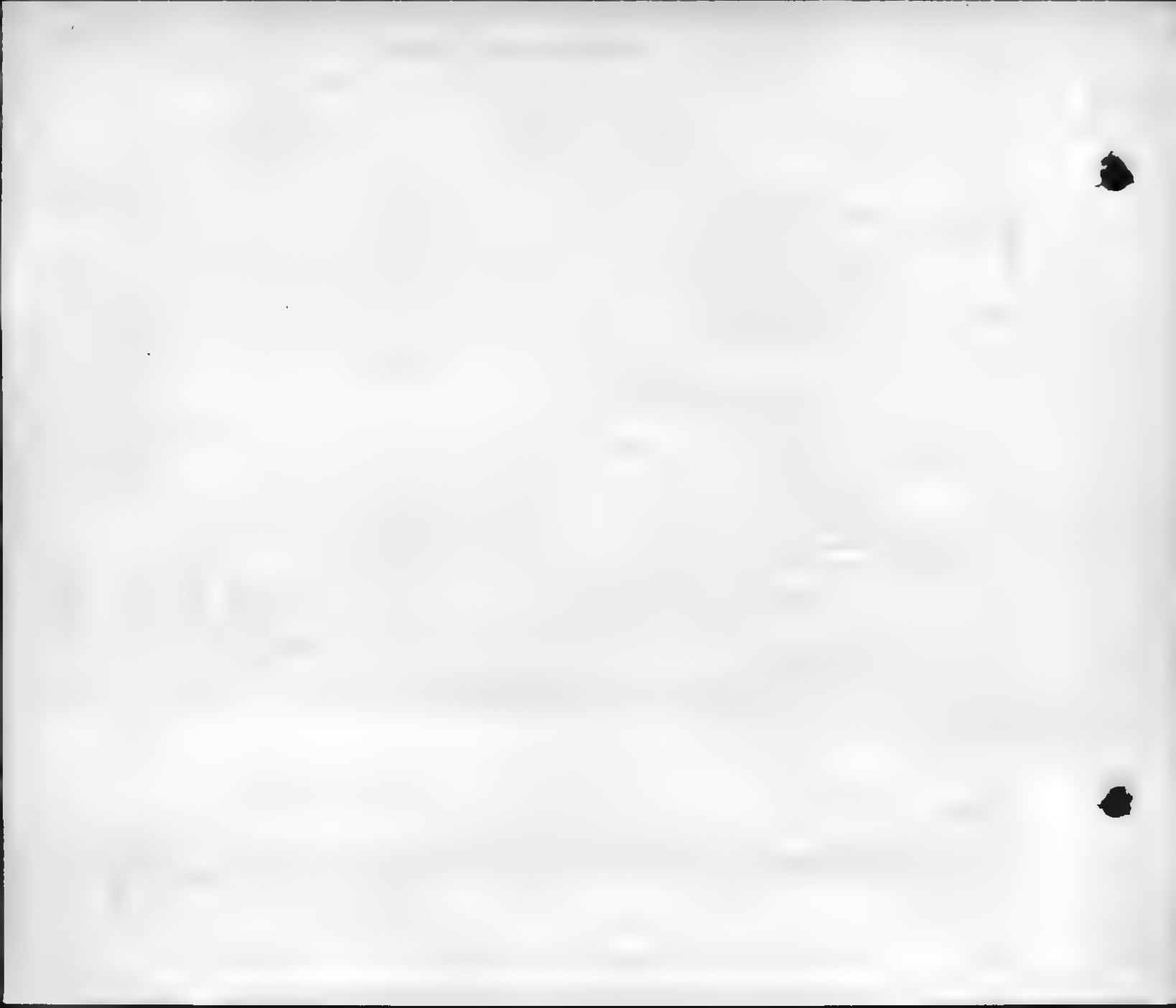
1131

CERTIFICATE OF DEATH

01135

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>24 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Haddaway</u> Last <u>Haddaway</u>		4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 8, 1900</u>
9. AGE (In years last birthday) <u>59 yrs.</u>		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hom.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E. Haddaway</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Wayman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>James F. Haddaway Jr. Heavitt Md</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12:30</u> to <u>1:30</u> that I last saw the deceased alive on <u>January 10</u> and that death occurred at <u>1:30</u> p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		DATE SIGNED <u>Jan 11 1959</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS <u>219 S. Washington St. Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-13-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Heavitt Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Heavitt md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Harkness</u> ADDRESS <u>Hawkins, St. Michaels, md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Harkness</u> DATE <u>JAN 13 '59</u>	
24b. REGISTRAR'S SIGNATURE			



FOR STATE
HEALTH DEPT.

VS. A15ME
BM 2/57

1
DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										01136	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										1153	
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If instit on Residence before adm ssion) a. STATE MARYLAND b. COUNTY TALBOT						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TRAPPE RURAL					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TRAPPE RURAL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MILDRED BREREWOOD HIGHLEY					4. DATE OF DEATH Month Day Year JAN 12 1959						
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1906		9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles W. Brerewood					14. MOTHER'S MAIDEN NAME Willie Mills						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)					16. SOCIAL SECURITY NO None		17. INFORMANT A B Highley Trappe Maryland			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) /revolving autopsy Acute alcoholism 2.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 0.29% DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH hours +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Korn Muelty					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 1-13-59	
EXAMINER'S NAME (Type) Welty					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, or other disposal (Specify) Burial			22b. DATE THEREOF Jan 15, 1959		22c. NAME OF CEMETERY OR CREMATORY Louis Spring Hill		22d. LOCATION (City, town, or county) (State) Easton Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service					ADDRESS Cambridge Maryland		24a. REC'D BY REGISTRAR DATE JAN 19 59		24b. REGISTRAR'S SIGNATURE Charles E. Hanna		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

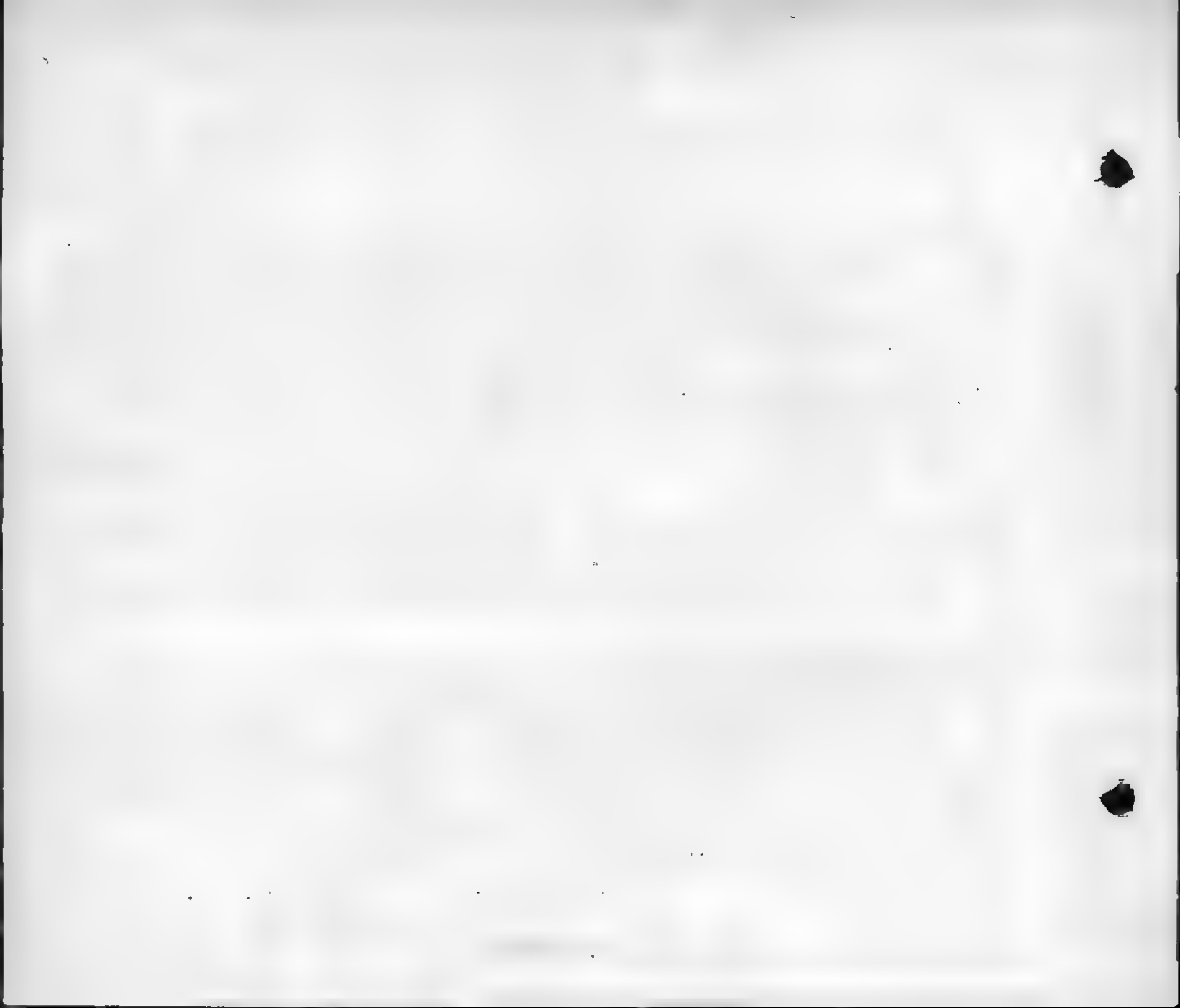
1132

CERTIFICATE OF DEATH

01137

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN TB 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		d STREET ADDRESS 17X-2	
3. NAME OF DECEASED (Type or print) MRS. Lillian First Middle Last Hildebrand		e. DATE OF DEATH Month 1 Day 21 Year 1959	
5. SEX Fe	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1888
9. AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR: Months 7 Days 14 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MR. John E. Zipprian		14. MOTHER'S MAIDEN NAME Catherine Erbe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Self	
17. INFORMANT Mrs. Lillian Hildebrand		Address 17X-2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 110X DUE TO Pulmonary embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of breast R DUE TO 7 years (c) 7 years		INTERVAL BETWEEN ONSET AND DEATH 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 5 , 1959, to JAN 21 , 1959, that I last saw the deceased alive on JAN 21 , 1959, and that death occurred at 8:00 A.M. from the causes and on the date stated above. DEATH SIGNATURE W. D. Noble M.D. 2 South Hanam St ADDRESS (Street, city or town, state) Easton, Md. DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/24/59	
22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Fous ADDRESS 2601 E. Madison St		24a. REC'D BY REGISTRAR JAN 24 1959	
24b. REGISTRAR'S SIGNATURE William H. Fous			



1133

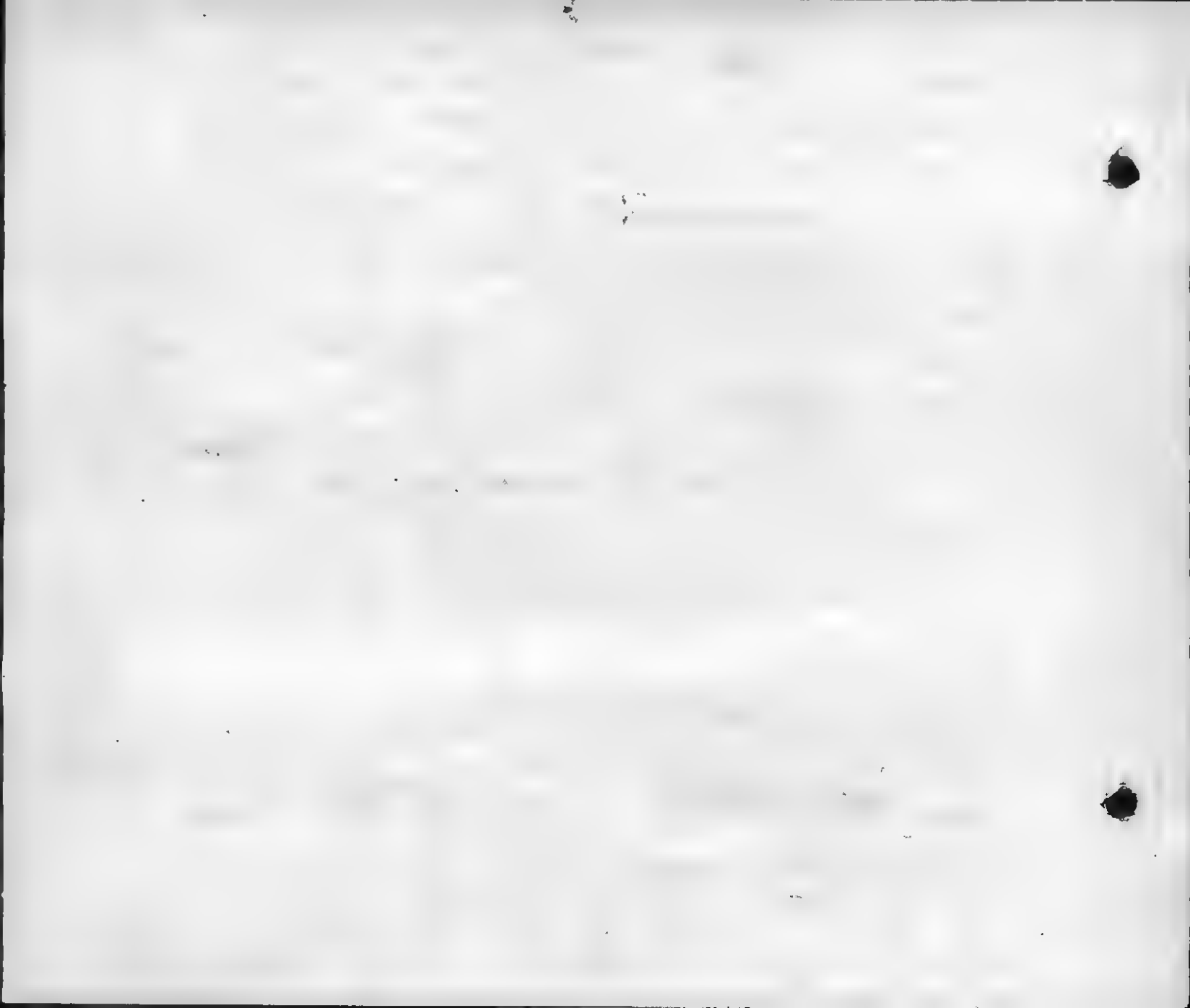
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton, md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Graham St				d. STREET ADDRESS Graham St			
3. NAME OF DECEASED (Type or print) First ISAAC Middle Hines Last JA				4. DATE OF DEATH Month 1 Day 12 Year 1959			
5. SEX MALE	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME ISAAC Hines				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT David Hines Easton, md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Generalized 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):						INTERVAL BETWEEN ONSET AND DEATH 3	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-18 , 19 58 , to 1/12/ , 19 59 that I last saw the deceased alive on 12-27 , 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton md DATE SIGNED P.B. Cox							
ACTUAL SIGNATURE P.B. Cox				M.D. Easton md			
PHYSICIAN'S NAME (Type) P.E. Cox							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1/15/59		Greenwood Cemetery			
23. FUNERAL DIRECTOR'S SIGNATURE James H. Smith, Easton, md				24a. REC'D BY REGISTRAR DATE JAN 22 1959		24b. REGISTRAR'S SIGNATURE Giles R. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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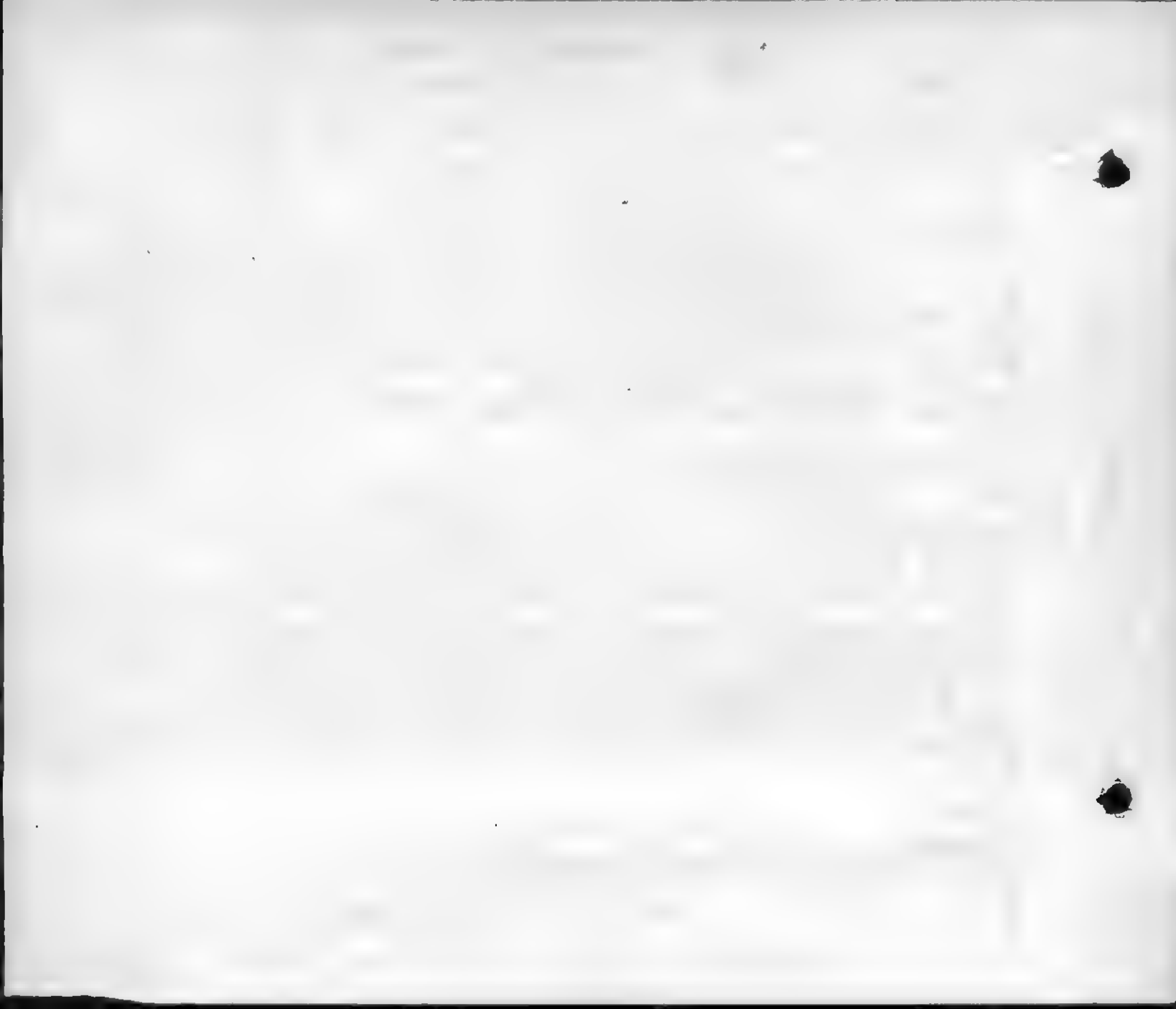
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1134

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 9 hrs. 35 min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Queen Anne c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesler d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Hervey		4. DATE OF DEATH Month 1 Day 31 Year 1959	
5. SEX Male	6. COLOR OR RACE White	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs 9 Months 35
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph P. Hervey		14. MOTHER'S MAIDEN NAME Arlene Timms	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 hrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/31, 1959 , to 1/31, 1959 , that I last saw the deceased alive on 1/31, 1959 , and that death occurred at 2:45 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Quantico, Md. DATE SIGNED 2/18/59			
ACTUAL SIGNATURE Irvin G. Hoyt M.D.		PHYSICIAN'S NAME (Type) Irvin G. Hoyt MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Buried	2/2/59	Stennisville	Quantico Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lure ADDRESS Church Hill Md		24a. REC'D BY REGISTRAR FEB 24 '59 DATE	24b. REGISTRAR'S SIGNATURE W. S. Kinnel



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VS A15 (4)
13M 9/55

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 5.0 and 5.2 (2-6-53) et
 1135
 CERTIFICATE OF DEATH

01139

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
c. LENGTH OF STAY IN 1b <u>5 days</u>				d. STREET ADDRESS <u>319 Goldsborough St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ethel R</u> Middle <u>Kinnaman</u> Last <u></u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 13, 1979</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Ross</u>				14. MOTHER'S MAIDEN NAME <u>Annie Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Dr. J. H. Kinnaman</u>		Address <u>Easton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1947</u> to <u>1-29-1959</u> that I last saw the deceased alive on <u>9-28-1959</u> and that death occurred at <u>2:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u></u> M.D. <u></u>				PHYSICIAN'S NAME (Type) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Jan 30, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Carter</u> ADDRESS <u>Easton Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>O. H. H. and</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

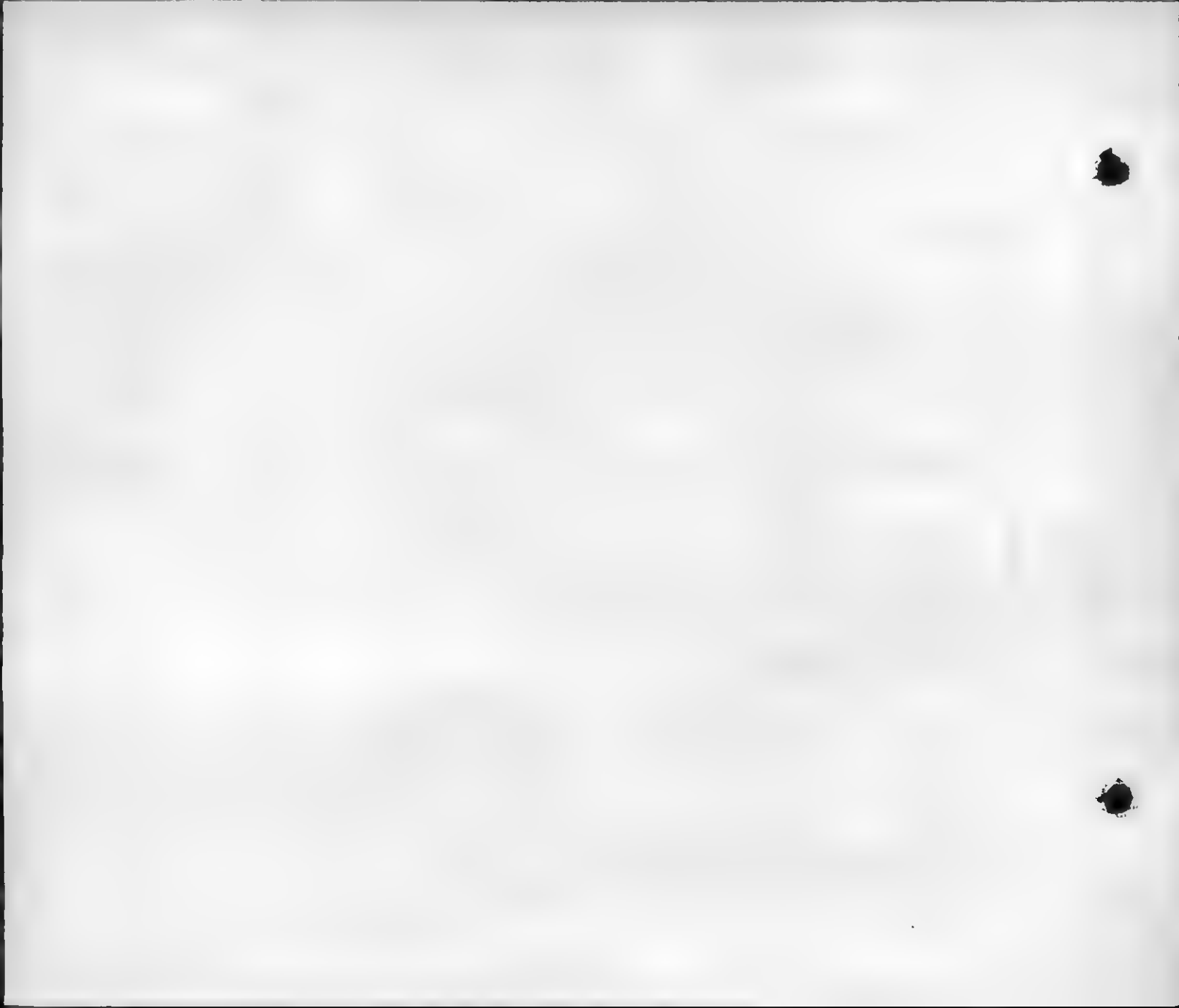
01140

1136

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN TB <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Shenbrooks</u> Last <u>Knotts</u>				4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 29, 1921</u>	
9. AGE (In years last birthday) <u>37 yrs</u>		10. UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>John Thomas Shenbrooks</u>				14. MOTHER'S MAIDEN NAME <u>Mary - Almina Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mrs. Katie H. Boyer, Harrington, Delaware</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple cerebral softening</u> <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Unknown</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of femur Diabetes mellitus Nephrosclerosis Arteriosclerosis</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Heart disease</u>			
20c. TIME OF INJURY Month <u>19</u> Day <u>1</u> Year <u>1959</u> Hour <u>a. m.</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Easton</u>				20g. (County) <u>Talbot</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>1-14</u> , 19 <u>59</u> , to <u>1-23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-23</u> , 19 <u>59</u> , and that death occurred at <u>5:25 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert W. Trever</u>				ADDRESS (Street, city or town, state) <u>202 Doven St. Easton, Md.</u>			
DATE SIGNED <u>1-24-59</u>							
PHYSICIAN'S NAME (Type) <u>202 Robert W. Trever</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-27-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Talbot County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>(Mrs) K. H. Boyer, Harrington, Del.</u>				ADDRESS <u>24a. REC'D BY REGISTRAR JAN 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. S. Kline</u>	



CERTIFICATE OF DEATH

01141

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <i>New Jersey</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. LENGTH OF STAY in 1b <i>6 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Alfred Smith Leap</i>				4. DATE OF DEATH Month Day Year <i>January 12 1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>July 27, 1893</i>	9. AGE (In years last birthday) <i>65 yrs</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardner</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>	
13. FATHER'S NAME <i>William Leap</i>				14. MOTHER'S MAIDEN NAME <i>Lydia Cole</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO NONE</i>				16. SOCIAL SECURITY NO. <i>UNK.</i>			
17. INFORMANT <i>HOSPITAL RECORD - EASTON, MD.</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive retroperitoneal hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rupture of aortic aneurysm</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Pathologist</i> , 19 <i>1959</i> , to <i>1959</i> , that I last saw the deceased alive on <i>1/11/59</i> , and that death occurred at <i>10 P.</i> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>E. C. H. Schmidt</i>				ADDRESS (Street, city or town, state) <i>2195 Washington St. Easton, MD.</i>			
PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>				DATE SIGNED <i>1/13/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>1/16/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>LAUNSIDGE CEMETERY</i>		22d. LOCATION (City, town, & county) (State) <i>WOOSTOWN, NEW JERSEY</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Frazier Conell</i>				ADDRESS <i>EASTON, MD.</i>		24a. REC'D BY REGISTRAR <i>JAN 15 1959</i>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1154

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels</u>				c. LENGTH OF STAY IN 1b <u>weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>St. Vincent Nursing Home</u>				e. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Thom</u> Last <u>Thomson</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 31, 1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR: Months <u></u> Days <u></u>		IF UNDER 24 HRS: Hours <u></u> Min <u></u>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen Smith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen Smith</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomson</u>				14. MOTHER'S MAIDEN NAME <u>Rena Belle Pratt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>220-12-7284</u>		17. INFORMANT <u>Mrs. J. H. Thomson</u>		Address <u>Offord Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction (heart attack)</u> 3.32X DUE TO <u>Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/21, 1958</u> to <u>1/8, 1959</u> , that I last saw the deceased alive on <u>1/4, 1959</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. J. E. Gordon</u> M.D. <u>12 N. Hanson</u>				DATE SIGNED <u>1/9/59</u>			
PHYSICIAN'S NAME (Type) <u>EASTON</u>				M.D. <u>M. H. Hanson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>Jan 10, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Offord</u>		22d. LOCATION (City, town, or county) (State) <u>Offord Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. H. H.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>JAN 13 59</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, the registrar must file it with the health department. After this certificate has been signed by the attending physician and completely filled in by the registrar, the registrar must file it with the health department. After this certificate has been signed by the attending physician and completely filled in by the registrar, the registrar must file it with the health department.



1138

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. STREET ADDRESS <u>RFD. # 3</u>			
3. NAME OF DECEASED (Type or print) First <u>Ella N.</u> Middle <u>Melune</u> Last <u>Melune</u>				4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 11, 1886</u>	
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
13. FATHER'S NAME <u>William Noble</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Oday</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>220-01-7813</u>		17. INFORMANT <u>Clement St. Melune</u> Address <u>Denton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atherosclerotic heart disease</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>				20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>				20g. (County) <u> </u>			
20h. (State) <u> </u>				20i. (City or town) <u> </u>			
20j. (County) <u> </u>				20k. (State) <u> </u>			
21. I certify that I attended the deceased from <u>Feb 1st</u> , 19 <u>59</u> , to <u>Feb 31st</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 31st</u> , 19 <u>59</u> , and that death occurred at <u>9:20 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>2195 Westinghouse St. Easton, Md.</u>			
DATE SIGNED <u>Feb 59</u>				DATE SIGNED <u>Feb 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>				22b. DATE THEREOF <u>2/4/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Cornwall Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Harry Williamson</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>			
24b. REGISTRAR'S SIGNATURE <u> </u>				24c. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1139

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		e. STREET ADDRESS 611 N. Washington St.	
3. NAME OF DECEASED (Type or print) Mrs. Margaret B. Murphy		4. DATE OF DEATH 1 - 7 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29 1892
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR: Months 6 Days 6 Hours 6 Min 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Barnes		14. MOTHER'S MAIDEN NAME Sadie Leonard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Henry C. Murphy, husband, - Same	
17. INFORMANT Henry C. Murphy, husband, - Same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 165X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 mos. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 1958 , to JAN. 7, 1959 , that I last saw the deceased alive on JAN. 7, 1959 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald H. Bartley M.D.		ADDRESS (Street, city or town, state) 9 N. Harmon St. Easton, Md.	
PHYSICIAN'S NAME (Type) DONALD F. BARTLEY M.D.		DATE SIGNED 1-9-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 9, 1959	22c. NAME OF CEMETERY OR CREMATORY Spring Hill	22d. LOCATION (City, town or county) (State) Easton Md
23. FUNERAL DIRECTOR'S SIGNATURE Robert Finch ADDRESS Easton Md		24a. REC'D BY REGISTRAR DATE JAN 13 1959	24b. REGISTRAR'S SIGNATURE Conrad A. Finch

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1141

CERTIFICATE OF DEATH

01145

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Lalbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Lalbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton, Rural.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton, Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home</i>		e. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Norman W. Cyster</i>		4. DATE OF DEATH Month Day Year <i>Nov 9 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 5, 1896</i>
9. AGE (In years last birthday) <i>62 yrs.</i>		10. IF UNDER 4 YEAR Months Days Hours Min <i>7 4</i>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dairy Business</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Frederick Cyster</i>		14. MOTHER'S MAIDEN NAME <i>Emma Jane Detweiler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or Unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs Schuyler L. Mellon, Afford, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic Coronary Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Multiple Sclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1955</i> to <i>1-9-</i> 19 <i>59</i> that I last saw the deceased alive on <i>12-1-</i> 19 <i>58</i> , and that death occurred at <i>2:15 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>13 Cox</i> M.D.		<i>Easton, Md.</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Jan. 13, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Afford Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Afford, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John D. Williams, Easton, Md.</i>		24a. REC'D BY REGISTRAR <i>DATE 1 3 59</i>	24b. REGISTRAR'S SIGNATURE <i>W. S. Hume</i>

THE HOSPITAL OR ATTENDING PHYSICIAN The form requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1140
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN b 3 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY TALBOT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Queen Anne d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle Pinkney Last Pinkney		4. DATE OF DEATH Month 1 - Day 13 Year 1959	
5. SEX Fe	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1920
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Reggie Pinkney		14. MOTHER'S MAIDEN NAME NORA BROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Toxic hypoadrenalism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal failure DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Term pregnancy to stillborn infant			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 to 19 , that I last saw the deceased alive on 8:30 A.M. and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2195 Washington St. Baltimore 16, Maryland DATE SIGNED 13 Jan 59			
ACTUAL SIGNATURE E. C. H. Schmidt M.D.			
PHYSICIAN'S NAME (Type) E. C. H. Schmidt			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Jan 18 59	
22c. NAME OF CEMETERY OR CREMATORY Springvale		22d. LOCATION (City, town or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE J. H. Moore ADDRESS 1000 N. ...		24a. REC'D BY REGISTRAR 1000 N. ...	
24b. REGISTRAR'S SIGNATURE 1000 N. ...		DATE JAN 19 59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



01147

1142

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. STREET ADDRESS <u>204 S. Aurora St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mac</u> Last <u>POLLARD</u>		4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1958</u>
9. AGE (In years last birthday) <u>0</u> yrs		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>6</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Pollard</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Creed</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Dorothy Creed Pollard</u>		Address <u>102 S. Aurora St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Emphysema, right</u> DUE TO <u>Pneumonia, right</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1958</u> to <u>1959</u> , that I last saw the deceased alive on <u>11 a.m.</u> , and that death occurred on <u>11 a.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		M.D. <u>2195. Washington St. 22 Jan 59</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>Easton 16, Maryland</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-24-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hollywood</u>	22d. LOCATION (City, town, or county) (State) <u>Washington Del</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>(Mrs.) R. H. Bryer, Harrington Del.</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>JAN 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1143
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Faaton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sreaton</u>	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>Main Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>F.</u> Last <u>Paule</u>		4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>B. Sta. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. Henry D. Foble</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Kent</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-30-9740</u>	
17. INFORMANT <u>Wm. M. Sode</u>		Address <u>Conowingo, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to <u>10 January, 1959</u> , that I last saw the deceased alive on <u>10 January, 1959</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.		ADDRESS (Street, city or town, state) <u>295 Washington St. 117-59</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		DATE SIGNED <u>Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1/14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>M. E. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Sreaton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey Wilkins</u>		ADDRESS <u>Federalburg, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JAN 14 1959</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Item 4 File # 1-23-59 at
1111 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN lb 4 days		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) d. STATE Tennessee		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Claude N. Price		4. DATE OF DEATH Month Jan. Day 14 Year 1959		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 1, 1925		9. AGE (In years last birthday) yrs 33		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Auto Agency		11. BIRTHPLACE (State or foreign country) Tennessee	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME C. N. Price		14. MOTHER'S MAIDEN NAME Henrietta Price		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Yes World War II		16. SOCIAL SECURITY NO 1413-36-8288	
17. INFORMANT Mrs. June Price		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute vaso-motor collapse 5870 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute hemolytic pneumonia DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 5 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Edema, cardiac failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) St Michaels md		20g. (County) St Michaels md		20h. (State) 1-15-59		21. I certify that I attended the deceased from 1-11-59 to 1-14-59 , that I last saw the deceased alive on 1-14-59 , and that death occurred at 8:50 PM , from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) Rodgersville, Tenn	
23. ACTUAL SIGNATURE Wm J. Tucker Jr		23. PHYSICIAN'S NAME (Type) Wm J. Tucker Jr		23. M. D. Wm J. Tucker Jr		23. DATE 1-15-59		23. SIGNATURE Wm J. Tucker Jr	
24a. REC'D BY REGISTRAR Wm J. Tucker Jr		24b. REGISTRAR'S SIGNATURE Wm J. Tucker Jr		24c. DATE 1-15-59		24d. TIME 1-15-59		24e. SIGNATURE Wm J. Tucker Jr	
25a. BURIAL, CREMATION, REMOVAL (Specify) Burial		25b. DATE THEREOF Jan. 18-59		25c. NAME OF CEMETERY OR CREMATORY Rodgersville		25d. LOCATION (City, town, or county) Rodgersville, Tenn		25e. (State) Tenn	
26. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tucker Jr		26. ADDRESS Wm J. Tucker Jr		26. CITY Wm J. Tucker Jr		26. STATE Wm J. Tucker Jr		26. ZIP Wm J. Tucker Jr	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/55



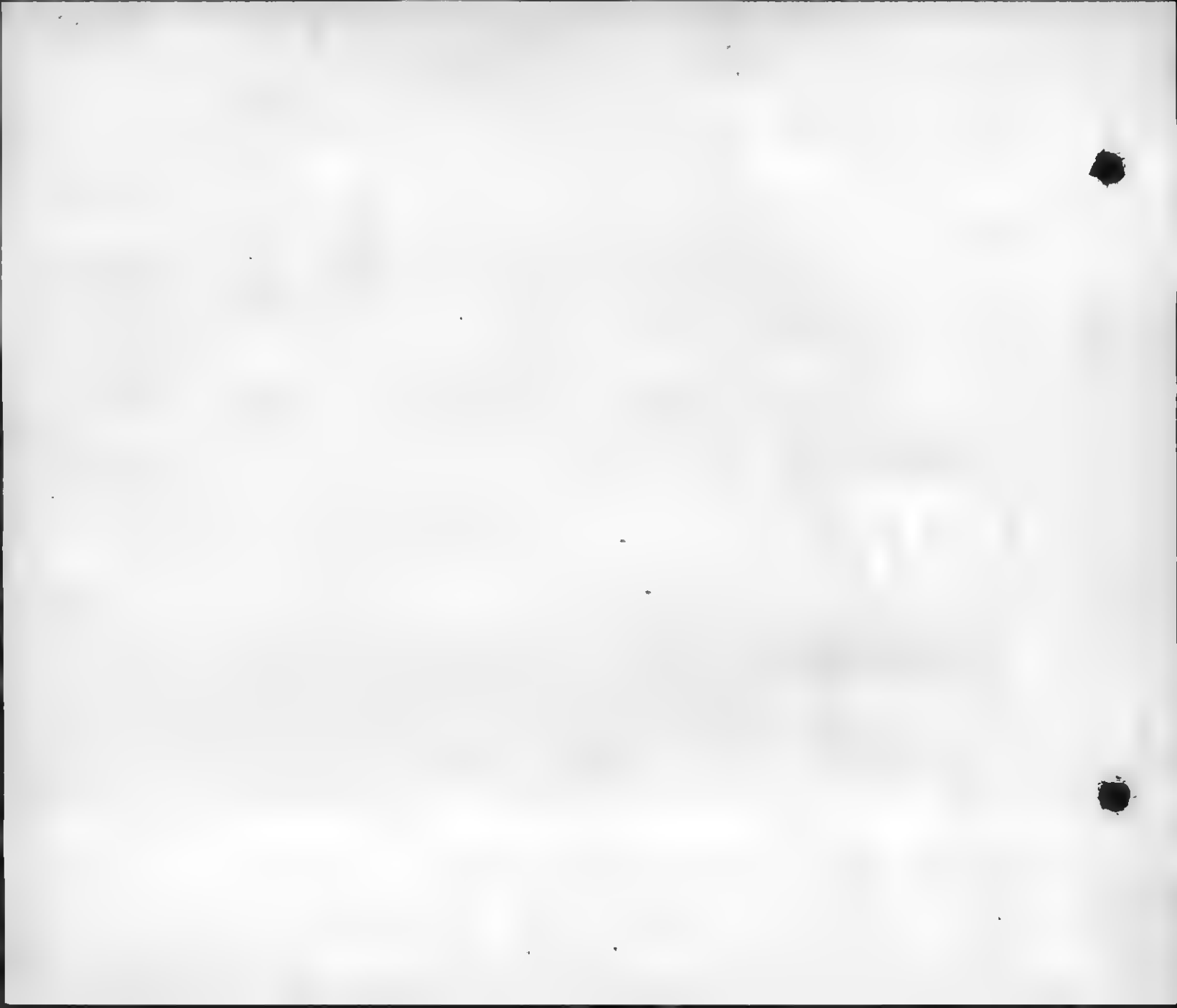
1145

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro 05X-			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial				d. STREET ADDRESS NONE			
3 NAME OF DECEASED (Type or print) Mrs. Elmira Gooden Russell				4. DATE OF DEATH 1-18-1959			
5. SEX Fe		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1888	
9. AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13 FATHER'S NAME Albert W. Gooden				14 MOTHER'S MAIDEN NAME TAMZA COOK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes				16 SOCIAL SECURITY NO. Unknown		17. INFORMANT Clarence Russell Greensboro Md.	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma of Liver							
151X DUE TO (b) Carcinoma of Stomach							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) ---							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 4, 1959 , to Jan 18, 1959 , that I last saw the deceased alive on Jan 18, 1959 , and that death occurred at 9 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. Arthur B. Cockiff M.D.				ADDRESS (Street, city or town, state) Easton, Md. DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1/21/59		Greensboro		Greensboro Md.	
23 FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais ADDRESS Greensboro, Md.				24a REC'D BY REGISTRAR DATE JAN 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01151

1155

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Trappe				c. LENGTH OF STAY IN 1b 40 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ELEANOR W. SAULSBURY				4. DATE OF DEATH Month Jan. Day 9, Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 4, 1870	
9. AGE (In years last birthday) 88 yrs		IF UNDER 1 YEAR Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME St. Clair Watts		14. MOTHER'S MAIDEN NAME Sara E. Lofland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Sarah Diffenderfer		Address Trappe, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1948 to 1/8, 1959 , that I last saw the deceased alive on 1/8, 1959 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Shepherd Jr M.D.				ADDRESS (Street, city or town, state) Easton DATE SIGNED 1/11/59			
PHYSICIAN'S NAME (Type) Dr. Shepard Krech, Jr.				Easton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 12, 1959		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newman & Son				ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DATE 1-15-59	
				24b. REGISTRAR'S SIGNATURE Edith S. Smith			



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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1-11-59, 1-19-59 at

CERTIFICATE OF DEATH

01152

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14160T</u>				c. LENGTH OF STAY IN 1b <u>17x</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address of institution) <u>Daughter's home</u> <u>Cecil Court Rural</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>GALAWAY</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>11</u> Year <u>19 59</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 18 1869</u>	
9. AGE (In years last birthday) <u>89</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>US Md</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joshuah Galaway</u>				14. MOTHER'S MAIDEN NAME <u>KATHERN ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL/SECURITY NO. <u>None</u>		17. INFORMANT <u>MARIE S Johnson</u> Address <u>Cordova</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>chronic</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Dec 20, 1958</u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>58</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kurt Lederer</u>				ADDRESS (Street, city or town, state) <u>Queen Anne Md</u>		DATE SIGNED <u>1-11-59</u>	
PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>People Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L Lane</u> ADDRESS <u>Church Hill</u>				24a. REC'D BY REGISTRAR <u>JAN 14 59</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	



1146

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN TB <i>17 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Elizabeth</i> Last <i>Smith</i>		4. DATE OF DEATH Month <i>January</i> Day <i>21</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 1888</i>
9. AGE (In years last birthday) <i>70 yrs</i>		10. IF UNDER 1 YEAR Months <i>70</i> Days <i>70</i> Hours <i>70</i> Min <i>70</i>	11. IF UNDER 24 HRS. Months <i>70</i> Days <i>70</i> Hours <i>70</i> Min <i>70</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>A.W.</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Roberts</i>		14. MOTHER'S MAIDEN NAME <i>Lula Jackson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>John E. Smith - son -</i>		Address <i>Claiborne, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac failure</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>atherosclerotic cardiac & cerebrovascular</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus, uremia, coarctation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <i>19</i> Month <i>19</i> Day <i>19</i> Year <i>19</i> a. m. <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 1952</i> to <i>1-21-1959</i> , that I last saw the deceased alive on <i>1-21-1959</i> , and that death occurred at <i>2:00 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thos. M. Beeber, Jr.</i>		DATE SIGNED <i>1-21-59</i>	
PHYSICIAN'S NAME (Type) <i>Thos. M. Beeber, Jr.</i>		ADDRESS <i>St. Michael, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>1-23-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Claiborne Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Claiborne, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Norman D. Marshall - St. Michael, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 27 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



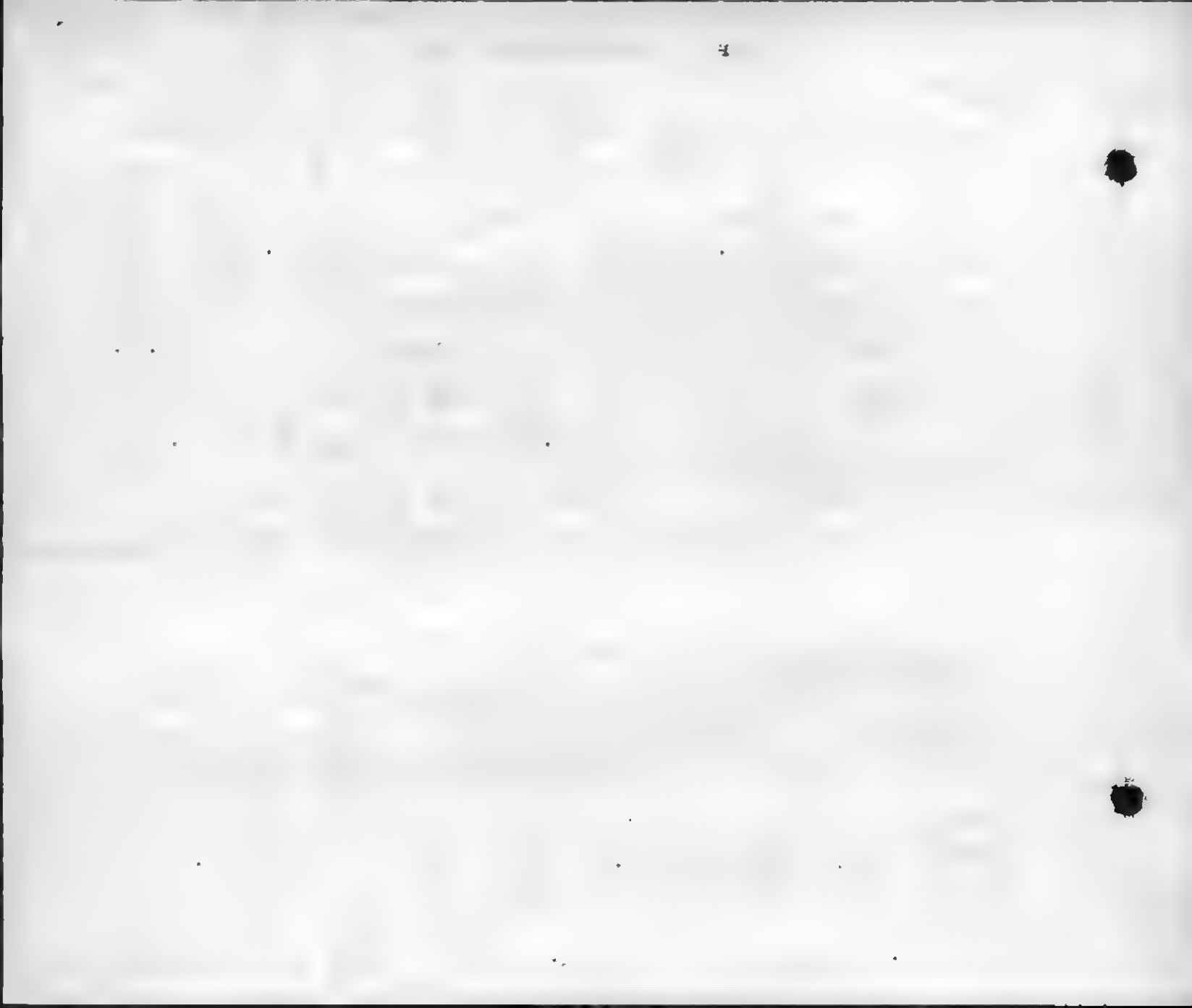
1157

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Easton		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) JENNETT C. TODD		4. DATE OF DEATH Jan. 12, 19 59	
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1864
9 AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Craft		14. MOTHER'S MAIDEN NAME Jennett Dulin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Walter Todd		Address Royal Oak, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 wk yes.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June, 1956 to 11-11-1959 , that I last saw the deceased alive on 1-11-1959 , and that death occurred at 7:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Easton, Md. 1-13-59			
ACTUAL SIGNATURE Shepard H		M.D.	
PHYSICIAN'S NAME (Type) Dr. Shepard Krech, Jr.		Easton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 15, 1959	22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	22d. LOCATION (City, town, or county) (State) Easton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, M.	
24a. REC'D BY REGISTRAR DATE JAN 15 '59		24b. REGISTRAR'S SIGNATURE William S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1147

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c LENGTH OF STAY IN 1b <u>22 dn.</u>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e STREET ADDRESS <u>21 Glenwood Ave.</u>			
3 NAME OF DECEASED (Type or print) First <u>Alfred</u> Middle <u>LAYMAN</u> Last <u>Tull</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1895</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REPAIRMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RADIO</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles E. Tull</u>				14. MOTHER'S MAIDEN NAME <u>Eudora C. Sterling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-05-1320</u>		17. INFORMANT <u>Mrs. Ethel M. Tull</u>		Address <u>21 GLENWOOD AVE. EASTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>2195 Washington St. N. W. 59</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE SIGNED <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton MD.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>John J. Carroll</u>				ADDRESS <u>Easton, MD.</u>		24a. REC'D BY REGISTRAR <u>JAN 14 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1158 CERTIFICATE OF DEATH

01156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>T. 1st</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Rock Hall</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> <u>14x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rio Vista Nursing Home</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) <u>Robert J. Warner</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1920</u>		9. AGE (In years lost-birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>30</u> Min. <u>30</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Warner</u>				14. MOTHER'S MAIDEN NAME <u>Ashley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Edward Pfeiffer--Rock Hall, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic coronary heart d</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cardiovascular disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-18</u> , 19 <u>58</u> , to <u>5-10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-10</u> , 19 <u>59</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Ray M. Reiser</u> M.D.				ST. MICHAELS			
PHYSICIAN'S NAME (Type) <u>Ray M. Reiser</u>				<u>1-12-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 14</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane</u>				24a. REC'D BY REGISTRAR <u>Jan 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles P. Kenna</u>	



1159

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McDaniel				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS McDaniel			
3. NAME OF DECEASED (Type or print) First Robert Middle Henry Last WARNER				4. DATE OF DEATH Month 1 Day 2 Year 1959			
5. SEX Male	6. COLOR OR RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/5/76	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY Oyster		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert WARNER				14. MOTHER'S MAIDEN NAME Unkown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO —		17. INFORMANT Address Mrs. Ebona Caldwell, McDaniel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 4 DUE TO atherosclerotic cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 6 hrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pneumonitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	Month 1	Day 2	Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) St Michaels md	(County) — (State) —
21. I certify that I attended the deceased from 1-2- , 19 59 , to 1-2- , 19 59 , that I last saw the deceased alive on 1-2- , 19 59 , and that death occurred at 1:30 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Guy M. Becker Jr M.D.				ADDRESS (Street, city or town, state) St Michaels md			
PHYSICIAN'S NAME (Type) Guy M Becker Jr				DATE SIGNED 1-5-59			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 1/5/59	22c. NAME OF CEMETERY OR CREMATORY Claribone Cem.		22d. LOCATION (City, town, or county) (State) Clariborne, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James B. Bell, Boston, Md.				ADDRESS —		24a. REC'D BY REGISTRAR DATE 8 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kross

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1160

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Easton				c. LENGTH OF STAY in 1b 5 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> rural Easton				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peachblossom			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CARLTON Middle R. Last WHITELEY				4. DATE OF DEATH Month January Day 16, Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 5, 1897	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive & tax Consultant wholesale candy				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George A. Whiteley				14. MOTHER'S MAIDEN NAME Annie F. Cheezum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W. 1				16. SOCIAL SECURITY NO. 214-32-7134		17. INFORMANT Mrs. Carlton R. Whiteley Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4. DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency (c) Diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH 45 min. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from AUG. 1958 to JAN. 16, 1959 , that I last saw the deceased alive on JAN 16, 1959 , and that death occurred at 4:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald F. Bartley				ADDRESS (Street, city or town, state) 9 N. HANSON ST. EASTON		DATE SIGNED 1-16-59	
PHYSICIAN'S NAME (Type) Donald F. Bartley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 19, 1959		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Maryland		24a. REC'D BY REGISTRAR DATE JAN 21 59	
				24b. REGISTRAR'S SIGNATURE S. S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1148

CERTIFICATE OF DEATH

Reg. Dist. No.

01159

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 20 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 S. WASHINGTON ST.		e. STREET ADDRESS 126 S. WASHINGTON ST	
3. NAME OF DECEASED (Type or print) First ABRAM Middle SEYDEL Last WISEL		4. DATE OF DEATH Month JAN. Day 22 Year 1959	
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 24, 1899
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAYLOR		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME MOSES WISEL		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. CHARLOTTE WISEL		Address 126 S. WASH. ST EASTON, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Occlusion DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 30 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential Hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1955 to Jan. 22, 1959 , that I last saw the deceased alive on Jan. 22, 1959 , and that death occurred at 6 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9 N. HANSON ST. EASTON, MD. DATE SIGNED 1-22-59			
ACTUAL SIGNATURE Donald F. Bartley		PHYSICIAN'S NAME (Type) DONALD F. BARTLEY, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-25-59	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON		22d. LOCATION (City, town, or county) (State) BALTO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Inc - 2100 Eutan Place		24a. REC'D BY REGISTRAR JAN 26 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneale			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 0237 1-21-59 et

1149

CERTIFICATE OF DEATH

01160

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Calbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 38 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				d. STREET ADDRESS R7 D#1			
3. NAME OF DECEASED (Type or print) First Thomas Middle H. Last Wyatt				4. DATE OF DEATH Month JAN Day 10 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 1883		9. AGE (In years last birthday) 75 1/2 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Wyatt				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Burley Wyatt, Federburg, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangled Remained in park, it 5610 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 days DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-8 , 19 59 , to 1-10 , 19 59 , that I last saw the deceased alive on 1-10 , 19 59 , and that death occurred at 9:40 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur B. Cecil				DATE SIGNED 1-14-59			
PHYSICIAN'S NAME (Type) Arthur B. Cecil				M.D. Easton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		Jan 13 1959		Denton		Denton, Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. L. Moore & Son				ADDRESS Denton		24a. REC'D BY REGISTRAR DATE JAN 19 '59	
						24b. REGISTRAR'S SIGNATURE Arthur B. Cecil	

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